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## BLEAK PROSPECTS: HOW HEALTH CARE REFORM HAS FAILED IN THE UNITED STATES

RICHARD A. EPSTEIN \*

*This Article examines the probable fate that awaits the systematic implementation of ObamaCare. Any effort to pile a massive new transfer and entitlement program on top of a hundred years of previous reforms is likely to fall prey to the law of diminishing marginal utility of additional forms of government intervention. That consequence is all the more likely for legislation that has strong redistributivist objectives but which lacks any techniques for dealing with the massive costs increases embedded in the program. A recent history of the Massachusetts health care initiative provides some indication of the inability to constrain costs except through the imposition of price controls that could easily drive private carriers into bankruptcy. The well-known Dartmouth Atlas, moreover, provides no evidence that there are massive inefficiencies that these price controls can bleed out of the system. The complex system of private health care exchanges or the certain expansion of Medicaid and the unlikely contraction of Medicare are likely to add only greater pressures to an already unworkable system.*

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## I. INTRODUCTION: DIMINISHING MARGINAL RETURNS TO EVERYTHING

Over the past two years, the United States has entered into a phase of active government. Yet of all the many items on the agenda of President Barack Obama, none has proved more contentious, and it appears more unpopular, than his health care initiative.<sup>1</sup> The statute has a peculiarly awkward and self-aggrandizing title: the Patient Protection and Affordable Health Care Act.<sup>2</sup> It is likely that ObamaCare, as it is now known, for better or worse, will not supply patients with protection from anything except their own best judgment. Nor will its heavy and convoluted administrative provisions make health care more affordable, even though it will, through a crazy-quilt set of taxes and regulations, shift the forms of health care distribution in ways that are at present only dimly known. As long and as convoluted as the ObamaCare legislation is, it is only a small down payment on a massive set of initiatives whose content will become clear, if at all, only through the regulations that are now being fought over on the key features of the bill. It seems clear that this incipient and chaotic health care revolution will, unless it is hindered, delayed, watered down, or

1. See, e.g., Jennifer Haberkorn, *Dems Run Away From Health Care*, POLITICO (Sept. 5, 2010), <http://dyn.politico.com/printstory.cfm?uuid=DE1E691B-18FE-70B2-A813ACC3D55691DE> ("A Kaiser Family Foundation poll . . . showed 43 percent of the public supports the [health care] overhaul and 45 percent are opposed. Much of the disagreement falls along party lines.").

2. Patient Protection and Affordable Care Act (ObamaCare), Pub. L. No. 111-148, 124 Stat. 119 (2010).

repealed, surely count as a larger and ultimately more dramatic change than the 1965 Medicare legislation which was one of the centerpieces of President Lyndon Johnson's Great Society.<sup>3</sup>

Before we turn to any of its particulars, it is useful to set out in a priori terms the reasons why ObamaCare is likely to crater and to do so in grand fashion. The key principle has nothing to do with health care in specific. Rather, it rests on the general proposition that there are diminishing marginal returns to any activity that government or private parties attempt, including increased government regulation. In the United States, we have experienced four major waves of government regulation in the past hundred years.

The first of those waves began with the progressive reforms of Woodrow Wilson's administration, especially in areas of trade regulation. That period saw the creation of the Federal Trade Commission in 1914<sup>4</sup> and the passage of the Clayton Act<sup>5</sup> that same year. The Clayton Act strengthened enforcement of the 1890 Sherman Anti-Trust Act,<sup>6</sup> while at the same time exempting both labor unions and agriculture from the strictures of the antitrust laws in a clear form of selective interest group regulation.

Matters slowed during the First World War and the 1920s, but the dislocations of the 1929 stock market crash and its aftermath ushered in a second wave of progressive reforms during the New Deal. The New Deal properly begins with Herbert Hoover's administration, and not Franklin Roosevelt's. Even before Roosevelt took office, Hoover presided over passage of the Smoot-Hawley Tariff,<sup>7</sup> the Davis-Bacon Act of 1931,<sup>8</sup> massive tax increases of the Revenue Act of 1932,<sup>9</sup> and the Norris-LaGuardia Act of

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3. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at subchapter XVIII of 42 U.S.C.).

4. Federal Trade Commission Act of 1914, Pub. L. No. 63-203, 38 Stat. 717 (codified as amended at 15 U.S.C. §§ 41-58 (2006)).

5. Pub. L. No. 63-212, 38 Stat. 730 (1914) (codified as amended at 15 U.S.C. §§ 12-27 (2006)).

6. 26 Stat. 209 (1890) (codified as amended at 15 U.S.C. §§ 1-7 (2006)).

7. Tariff Act of 1930 (Smoot-Hawley Tariff), Pub. L. No. 71-361, 46 Stat. 590 (codified as amended at 19 U.S.C. §§ 1202-1683g (2006)).

8. Pub. L. No. 71-798, 46 Stat. 1494 (codified as amended at 40 U.S.C. §§ 3141-3148 (2006)).

9. Pub. L. No. 72-154, 47 Stat. 169.

1932.<sup>10</sup> Each of these actions in its own way limited the sphere of private enterprise and increased the scope of government power over the economy. The pace of that regulatory oversight only increased during the Roosevelt years, much of whose legacy is still in place. This legacy includes the National Labor Relations Act,<sup>11</sup> the Agricultural Adjustment Act,<sup>12</sup> the Securities and Exchange Act of 1934,<sup>13</sup> the Fair Labor Standards Act,<sup>14</sup> and of course, the creation of the Social Security system in 1935.<sup>15</sup> As with the legislation that preceded it, most of these statutes increased government power over the economy, particularly by strengthening labor and agriculture cartels until they became a fixed feature of the American economy.

The third wave of regulation is a creature of the 1960s, the Johnson Era, which continued through the Nixon Administration in the early 1970s, proving that Democrats have no monopoly on big government. The 1960s-era legislation was directed less toward the traditional beneficiaries of regulation: agriculture, labor, and consumer protection. Instead, it was largely a conscious effort to increase the rate of transfer payments, either express or implicit, from rich to poor.<sup>16</sup> Much of it had to do with the Civil Rights Act of 1964<sup>17</sup> and the Medicare and Medicaid legislation.<sup>18</sup> On other fronts, the third wave of legislation regulated environmental protection,<sup>19</sup> endangered species,<sup>20</sup>

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10. Pub. L. No. 72-65, 47 Stat. 70.

11. Pub. L. No. 74-198, 49 Stat. 449 (1935) (codified as amended at 29 U.S.C. §§ 151-169 (2006)).

12. Pub. L. No. 73-10, 48 Stat. 31 (1933) (codified as amended at 7 U.S.C. §§ 601-627 (2006)).

13. Pub. L. No. 73-291, 48 Stat. 881 (codified as amended at 15 U.S.C. §§ 78a-78kk (2006)).

14. Pub. L. No. 75-718, 52 Stat. 1060 (1938) (codified as amended at 29 U.S.C. §§ 201-219 (2006)).

15. Social Security Act of 1935, Pub. L. No. 74-271, 49 Stat. 620 (codified as amended in scattered sections of 42 U.S.C.).

16. *See* Economic Opportunity Act of 1964, Pub. L. No. 88-452, 78 Stat. 508 (repealed 1981) (creating numerous programs intended to provide social services to the poor at the expense of taxpayers).

17. Pub. L. No. 88-352, 78 Stat. 241.

18. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at 42 U.S.C. §§ 1395-1396 (2006)).

19. *See, e.g.*, Clean Water Act of 1972, Pub. L. No. 92-500, 86 Stat. 816 (codified as amended at 33 U.S.C. §§ 1251-1387 (2006)); National Environmental Policy Act of 1969, Pub. L. No. 91-190, 83 Stat. 852 (codified as amended at 42 U.S.C. §§

employee pensions,<sup>21</sup> and workplace safety.<sup>22</sup> Although some of these interventions are sensible, most are not. They naïvely assume that wealth transfer is a zero-sum game and that society only faces a question as to how great a loss in wealth is needed to secure any increase, by some elusive standard, in individual utility. Without question, all of this legislation increases the government's role in both the regulation of private businesses and in the direct operation of the economy.

These first three waves form the backbone of our modern regulatory state. Yet despite this large regulatory overhang, the newest round of feverish legislative activity contains not one single word about deregulation, which would have the dual benefit of raising tax revenues and reducing government expenditures.<sup>23</sup> Far from alleviating earlier burdens, this latest wave of regulation is, in fact, far more intrusive than any of the previous three. My view is that with this wave of regulation, the United States has now crossed the point of diminishing returns—even if, as I believe was the case, we had not crossed it earlier. The expected cost of running the entire regulatory apparatus, especially its health care component, will turn out to be exceedingly high under any accurate accounting of the burdens that these measures impose. On the other side, the supposed benefits of such regulation will turn out to be both evanescent and uncertain.

The only certain consequence of the ObamaCare regulation is a dismal one: an unfortunate mad scramble of political intrigue as various health care providers and groups seek to secure favorable places or reimbursement rates for their own particular programs. In my judgment,

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4321–4370 (2006)); Clean Air Act of 1963, Pub. L. No. 88-206, 77 Stat. 392 (codified as amended at 42 U.S.C. §§ 7401–7671 (2006)).

20. Endangered Species Act of 1973, Pub. L. No. 93-205, 87 Stat. 884 (codified as amended at 16 U.S.C. §§ 1531–1544 (2006)).

21. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 29 U.S.C. and 26 U.S.C.).

22. Occupational Safety and Health Act of 1970, Pub. L. No. 91-596, 84 Stat. 1590 (codified as amended at 29 U.S.C. §§ 651–678 (2006)).

23. See, e.g., Richard A. Epstein & David A. Hyman, *Controlling the Costs of Medical Care: A Dose of Deregulation* 18, 38 (Univ. of Chi. Law & Econ., Olin Working Paper No. 418, 2010), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1158547](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1158547).

the persistent decline in both liberty and prosperity in the United States will continue apace. The great battle of the next generation will not identify those able to garner the lion's share of a social gain created by a vibrant economy. It will address a more tragic question: in a time of falling wealth, who is going to bear the brunt of the decline? Generally speaking, fights over prosperity add some levity into the air. Fights over deprivation, on the other hand, only produce a level of ugly recrimination that nobody wants to witness. As we all know, the political climate in Washington today seems to be more divisive and acrimonious than it has been in many years.<sup>24</sup> The resentments are not limited to bipartisan quarrels. They go to fundamental differences in worldview that drive every modern controversy. These differences play out over all aspects of health care reform at the state and federal level. The main dispute is over the ultimate measure of social welfare in the United States.

I am a dyed-in-the-wool traditional, consequentialist *Paretian*—a term that derives from Vilfredo Pareto, who first identified this measure of social welfare.<sup>25</sup> To be sure, it seems hard to get worked up over a term that no one quite understands or a great economist whom no one quite remembers. Paretianism does not raise a banner under which a candidate can win a lot of votes. But it is worthwhile to explain why this measure of social welfare proves so attractive in principle. Under the Pareto principle, the differences in wealth between one person and another are rendered irrelevant. Instead, the key question to ask about any coercive form of government interaction is whether or not it is capable of generating a Pareto improvement. What that term means is this: is it possible to find a way, through state intervention, to make at least some people better off and nobody else worse off? Ideally, it would be better if everyone could be made better off

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24. For one side of the political coin, see Richard Sisik, *Glenn Beck Says America is Wandering into the Darkness Because of 'Divisive Politics'*, N.Y. DAILY NEWS (Aug. 28, 2010), [http://www.nydailynews.com/news/national/2010/08/28/2010-08-28\\_glenn\\_beck\\_says\\_washington\\_rallies\\_purpose\\_is\\_to\\_help\\_lead\\_america\\_out\\_of\\_the\\_dar.html](http://www.nydailynews.com/news/national/2010/08/28/2010-08-28_glenn_beck_says_washington_rallies_purpose_is_to_help_lead_america_out_of_the_dar.html). For the other side, see Bob Herbert, *America Is Better than This*, N.Y. TIMES (Aug. 28, 2010), <http://www.nytimes.com/2010/08/28/opinion/28herbert.html> (“[Glenn] Beck is an ignorant, divisive, pathetic figure.”).

25. See VILFREDO PARETO, *MANUAL OF POLITICAL ECONOMY* 261 (Ann S. Schwier & Alfred N. Page eds., Ann S. Schwier trans., 1971) (1906).

simultaneously.<sup>26</sup> But even if only the first objective can be achieved, and no one is made worse off, it would no longer be necessary to look with suspicion on the differentials in wealth that emerge through voluntary market transactions or government interventions. The second objective, however, which is to make everyone better off simultaneously, is less problematic because both parties receive gains and it is not necessary to worry unduly about exactly which party happens to get which particular benefit. State coercion finds it more difficult to reach that position of mutual advantage, though in select cases—such as the control of force or monopoly—it can.

So as long as you are expanding the size of the social pie, competitive forces will tend to create wealth distributions that will be less extreme than it might first appear. This proposition holds even with respect to the very rich. If the rich compete for their economic returns, much like monopoly profits, they will be exposed to pressure from new entrants into their line of business, and the “free money” to which all of us aspire will be available to none of us. So we work to expand the pie knowing that each individual will take care of his or own slice—so long as the government role is circumscribed.

## II. SOCIAL WELFARE AND HEALTH CARE

At this juncture, our question becomes: how should this Paretian worldview be applied to the problem of healthcare? The answer is to start with deregulation where the social returns are likely to be the greatest. There are too many layers of regulation in the United States health care system. Many of them have survived for purely parochial or historical reasons. Virtually all of these reforms have proved unwise and should be eliminated.

First, we should remove the present prohibitions on interstate competition with respect to insurance in the individual and in the group markets.<sup>27</sup> Given that politics often makes for strange bedfellows, it should come as no

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26. I have argued for stricter standards of social improvement, with constraints on the division of the surplus in order to control factional behavior. See RICHARD A. EPSTEIN, *BARGAINING WITH THE STATE* 79–82, 98–103 (1993).

27. See McCarran–Ferguson Act, 15 U.S.C. §§ 1011–1015 (1945).



surprise that ObamaCare took the opposite tack.<sup>28</sup> Thus, any government that actively seeks a more comprehensive system of redistribution will soft-pedal deregulation in order to keep the support of those insurance companies that reap, or at least think they reap, their monopoly profits from state barriers to entry.

The position of these insurance companies is, however, always made more precarious by yet another regulatory feature that merits rapid extinction: insurance mandates. Companies that want to write insurance policies are always free to withdraw from the business, which they will not do because, by taking that step, they lose all chance to recover their sunk costs and to make their future profits. So wedded to the marketplace, they must comply with certain minimum standards imposed by either state or federal mandates, all of which gum up the operation of voluntary markets.<sup>29</sup> These are not isolated events. The Council for Affordable Health Insurance (CAHI) produced a detailed catalogue of some 1,961 state mandates as of 2008. Its report contained the warning that “more [mandates] are on their way.”<sup>30</sup>

State governments are not the only actors in this game. Congress passed a federal mandate during the height of the financial crisis, in September 2008, aiming for parity in mental health benefits for all people in the United States enrolled in private plans.<sup>31</sup> The effect of such mandates, many hundreds of which are now in effect, often goes unobserved on a daily basis but its cumulative effect is real. It is, invariably, to reduce the sum of consumer and producer surplus with respect that both customers and their insurers derive from the voluntary plans that remain in

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28. Jennifer Haberkorn, *Health Law Could Ban Low-Cost Plans*, POLITICO (June 8, 2010), <http://dyn.politico.com/printstory.cfm?uuid=142CBE3B-18FE-70B2-A82B15071E682918>.

29. VICTORIA CRAIG BUNCE & JP WIESKE, COUNCIL FOR AFFORDABLE HEALTH INS., HEALTH INSURANCE MANDATES IN THE STATES 2008, at 2 (2008), *available at* [http://www.cahi.org/cahi\\_contents/resources/pdf/HealthInsuranceMandates2008.pdf](http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf). For updates, see VICTORIA CRAIG BUNCE & JP WIESKE, COUNCIL FOR AFFORDABLE HEALTH INS., HEALTH INSURANCE MANDATES IN THE STATES 2010, (2010), *available at* [http://www.cahi.org/cahi\\_contents/resources/pdf/MandatesintheStates2010.pdf](http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010.pdf).

30. BUNCE & JP WIESKE, HEALTH INSURANCE MANDATES IN THE STATES 2008, *supra* note 20, at 2.

31. Emergency Economic Stabilization Act of 2008, Pub. L. No. 110-343, 122 Stat. 3765, 3881–93 (to be codified at 29 U.S.C. § 1185a and 42 U.S.C. § 300gg-5).

business. In concrete terms, CAHI “estimate[d] that mandated benefits currently increase the cost of basic health coverage from a little less than 20% to more than 50%, depending on the state and its mandates.”<sup>32</sup>

These numbers should not be ignored. On theoretical grounds alone, the size of the consumer and producer surplus has to decrease as the number and severity of mandates increase. If the new item was worth more than it cost, health care providers and insurers would have every incentive to include it in the basic plan, by sharing the gains. But a smaller combined surplus can still be positive, so that those plans remain in place so long as both sides can absorb the hit. This reduction in the combined surplus, however, technically counts as a social loss even if it is never recorded in any official social account that looks solely at the numbers of insured persons currently on the private rolls. But on some occasions, the size of the tax comes to exceed the combined surplus to the parties, and the insurance coverage dissolves. It is yet another instance of the principle of diminishing marginal social returns. When the government starts putting on the next round of mandated benefits, the entire package is no longer worth having. Since the insurer cannot get rid of that cargo that makes the boat too heavy, the boat capsizes and sinks, thereby increasing the number of uninsured individuals.

This is not a small phenomenon. Over the last thirty years, the number of people with employer plans dropped from about 60% to 50%.<sup>33</sup> Even so, the precise numbers really do not matter; what really counts is that the direction of the trend is inexorable, and its size is not inconsiderable. Yet once the employer boat is capsized by mandates, the individuals who are left to fend for themselves in the individual and small group markets, or on public support, find it rough going indeed. The good news is that these trends should be reversible. Therefore, with greater competition and fewer mandates, the voluntary market

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32. BUNCE & JP WIESKE, *HEALTH INSURANCE MANDATES IN THE STATES* 2008, *supra* note 29, at 2.

33. MARK W. STANTON, U.S. DEP'T OF HEALTH AND HUMAN SERVS., AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, *EMPLOYER-SPONSORED HEALTHCARE: TRENDS AND ACCESS* (2004), *available at* <http://www.ahrq.gov/research/empspria/empspria.pdf>.

should correspondingly revive as people are allowed to buy, to suit their own preferences, a lower level of insurance protection for a lesser sum of money.

As a social analyst, it is dangerous to base one's work on some predetermined notion of what people need for their own good. It is not that ordinary people are perfect judges of their own character and aims. It is that they, with their social network—family, employers, friends, church groups, and other agents—will generally do a lot better making judgments about their individual needs than the United States government. To put it delicately, the administrative agencies of the United States are not exactly run by individuals whose constitutional and economic wisdom is beyond reproach.

So, the essential logic of the small-government Pareto-improvement approach is to identify and remove these large pockets of unwise regulation. This path cuts down state administrative costs, increases the level of private choice, opens access, and raises tax revenues. People will flock back to insurance markets as the price for coverage goes down. Unfortunately, the dominant philosophy in Washington today moves in exactly the opposite direction. Even the Chamber of Commerce, traditionally no bastion of redistributionists, has an agenda that includes many of the most objectionable features that made their way into ObamaCare. These include: “[e]liminating the use of pre-existing conditions or health status; [g]uaranteeing that any individual or entity will be issued a policy; [g]uaranteeing that policies will not be revoked; [p]lac[ing] reasonable limits on rating differences; [s]ubsidies for those who cannot afford coverage.”<sup>34</sup>

This agenda shows no interest in designing legislative reforms to promote Pareto improvements. On the contrary, it evinces a concern for the elimination of wealth differentials on the assumption that income redistribution is one of the major objectives of health care reform. This shift in approach is no small adjustment. It is a profound transformation of how we think about the role of

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34. *Access to Affordable Health Care*, U.S. CHAMBER OF COMMERCE <http://www.uschamber.com/issues/health/access-affordable-health-care> (last visited Oct. 16, 2010).

government. One stylized numerical illustration highlights the difference between the Paretian view and redistributionist points of view. Start with ten people whose current welfare, for simplicity, equals ten units of wealth. Now one of them improves to twelve units of wealth while everyone else remains at ten units. A Paretian is quite happy about that transformation because it generates a net improvement of two units of wealth.<sup>35</sup>

Yet that example, which illustrates a social improvement under the Pareto standard, counts as anything but a success if a strong form of egalitarianism is allowed to influence the shape of our ultimate social goal. On that egalitarian assumption, any deviation from that initial distribution of parity which allows one person to advance more than any other can no longer be regarded as an unquestionable social improvement. It can be regarded as a festering source of social unrest in the form of rising economic inequality. There is no question that many supporters of health care reform are driven not by a desire to expand the pie but rather by their profound sense that equalization of the size of each slice is the first order of business. In a press conference, here is what Senator Max Baucus<sup>36</sup> said about this issue:

Too often, too much of late, the last couple . . . years, the maldistribution of income in America has gone up way too much, the wealthy are getting way, way too wealthy, and the middle income class is left behind. Wages have not kept up with the increased income of the highest incomes of Americans. This legislation will have the effect of addressing that maldistribution of income in America.<sup>37</sup>

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35. I use wealth in this example because it is more easily measured than utility. In principle, however, the same argument holds even if we deal with subjective utility. All we need to do is report that every person but one remains the same, and that last person experiences an improvement in his or her personal position. But utilizing wealth is preferable in these examples, because it is a publicly observable unit which better facilitates comparisons and overall assessments. A flawed measure that can be counted is better for social purposes than a more reliable theoretical standard that proves unadministrable in practice.

36. Senator Baucus also, incidentally, admitted to not reading the entire ObamaCare bill. See Jordan Fabian, *Key Senate Democrat Suggests That He Didn't Read Entire Healthcare Reform Bill*, THE HILL (Aug. 25, 2010), <http://thehill.com/blogs/blog-briefing-room/news/115749-sen-baucus-suggests-he-did-not-read-entire-health-bill>.

37. *Dem Senator: Health Legislation Will Address the "Mal-Distribution of Income in America,"* REAL CLEAR POLITICS (Mar. 25, 2010),

It is hard to know where to begin with this hyperbolic statement. The first point goes to implicit rejection of the Pareto formula. The rich are getting “way too wealthy” even if their wealth does not come from transfer payments taken from the poor. For Baucus, it is the size of the gap that is the wrong; not the source of its origin. Yet increased wealth in the system has all sorts of collateral consequences, including higher tax revenues for the United States Treasury. On this point, tax cuts increase overall wealth and tax revenues, as is well illustrated by this chart from the Internal Revenue

## Taxes and the Rich

Income taxes paid, in billions of dollars, by  
adjusted gross income, in 2003 and 2008

	2003	2008	Increase
\$200,000 or more	\$313	\$537	72%
\$1 million or more	132	249	89
\$5 million or more	55	118	115
\$10 million or more	35	84	140

Source: IRS, Statistics of Income, Table 1.1

Service (IRS).<sup>38</sup>

The data are even more impressive than this table indicates, for in any dynamic sense, lower rates translate into higher tax revenues. Government estimates usually rely on the naïve assumption that changes in tax rates do not alter behavior, when quite the opposite is true. In one of its most recent (and sound) diatribes against higher taxation, the Wall Street Journal published:

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[http://www.realclearpolitics.com/video/2010/03/25/dem\\_senator\\_health\\_legislation\\_will\\_address\\_the\\_mal-distribution\\_of\\_income\\_in\\_america.html](http://www.realclearpolitics.com/video/2010/03/25/dem_senator_health_legislation_will_address_the_mal-distribution_of_income_in_america.html).

38. See STATISTICS OF INCOME DIVISION, IRS, tbl. 1.1 (2010), available at <http://www.irs.gov/pub/irs-soi/08in11si.xls>; STATISTICS OF INCOME DIVISION, IRS, tbl. 1.1 (2005), available at <http://www.irs.gov/pub/irs-soi/03in11si.xls>.

According to the most recent IRS data on actual tax payments, total revenues collected over the period 2003-07 were about \$350 billion higher than Joint Tax and the Congressional Budget Office predicted when the 2003 tax cuts were enacted. Moreover, the wealthiest taxpayers paid a *larger* share of all income taxes from the beginning to the end of this period. The IRS data show that in 2003 those with incomes above \$200,000 paid \$313 billion in income tax. By 2007 they paid \$610 billion.<sup>39</sup>

Of these trends, Senator Baucus is blissfully ignorant. Worse still, Baucus assumes descriptively that a ponderous health care bill will have the effect of moving wealth from poor to rich simply because that comports with his intention. But here the crisscross pattern of provisions will vindicate the law of unintended consequences by inducing a set of displacements and responses that could easily lead to losses to individuals who may actually like their current situation, which they will not be able to replicate under the new legislation. In addition, administrative drag and perverse incentives mean there will be less wealth to go around, which cannot help those who are poor. A better solution is to expand the pie and worry about distribution only after those allocative gains are made, by a policy that I like to call “redistribution last.”<sup>40</sup>

### III. OVER THE EDGE

In its largest sense, the major problem for any program of redistribution is whether it can be executed in ways that do not shrink the size of the pie. In the case of ObamaCare, the correct answer is *no*, even if the answer for more modest programs may be *yes*. The *yes* answer for the modest state programs comes from my sense, shared by many others,<sup>41</sup> that low levels of persistent government redistribution will be met with a high level of popular acceptance. If anyone

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39. *The \$31 Billion Revenue Fantasy*, WALL ST. J. (Aug. 28, 2010), <http://online.wsj.com/article/SB10001424052748703876404575200621394266894.html> (emphasis in original).

40. Richard A. Epstein, *Decentralized Responses to Good Fortune and Bad Luck*, 9 THEORETICAL INQUIRIES IN L. 309 (2008).

41. See generally, Arthur C. Brooks, *A Nation of Givers*, THE AMERICAN, (Mar./Apr. 2008), <http://www.american.com/archive/2008/march-april-magazine-contents/a-nation-of-givers>.

watches how people spend their own money, they may not tithe themselves the full 10%, but they are always willing *up to a point* to help out through churches, other social groups, hospital drives, and public service campaigns for those less fortunate than themselves. However, like every other good thing on planet Earth, too much of a good thing becomes a bad thing. The law of diminishing marginal returns to scale also applies to charitable endeavors. In other words, the marginal cost of extra units of redistribution relative to their benefit eventually goes negative. The great danger that I see in the current health care system is that we have now passed the point of optimal redistribution and are very much on the downward slide. I think that today's resentments have all coalesced around this basic concern of the median voter in the United States: "As hard as I work, am I left worse off than I was before because of a series of programs that allow opportunists to profit at my expense?"<sup>42</sup>

To go beyond health care for the moment, take President Obama's announcement of yet another misguided program with respect to additional relief for those people who have fallen behind on their mortgage payments.<sup>43</sup> It turned out that the dominant response that came to the White House was from people in control of their own mortgages saying, "Why do I want to live in a country which is going to tax me enough so they might throw *me* into default?"<sup>44</sup> What should be done with these mortgages is to allow the foreclosures. Let the property then return to the market at their lower but more accurate valuations. At that point, new sales—which fell to an all-time low in July 2010<sup>45</sup>—can pick up,

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42. For an example of this concern, see John Hood, *The Great Redistribution Machine*, NAT'L REV. ONLINE (Mar. 27, 2007), <http://www.nationalreview.com/corner/139731/great-redistribution-machine/john-hood>.

43. Helping Families Save Their Homes Act of 2009, Pub. L. No. 111-22, 123 Stat. 1632. For my criticism of this type of legislation, see Richard A. Epstein, *The Subprime Crisis: Why One Bad Turn Leads to Another*, 2 J. BUS. ENTREPRENEURSHIP & L. 198 (2008).

44. See, e.g., John W. Schoen, *No 'Magic Bullet' in Obama Housing Relief Plan*, MSNBC.COM (Feb. 19, 2009), <http://www.msnbc.msn.com/id/29260537/> ("Many homeowners, some of whom also are struggling to make payments, are furious at the prospect of seeing their taxes used to help pay their neighbor's mortgage.").

45. *New Home Sales at All-Time Low*, CBS NEWS (Aug. 25, 2010), <http://www.cbsnews.com/stories/2010/08/25/business/main6804275.shtml> ("[N]ew home sales fell 12.4 percent in July from a month earlier to a seasonally adjusted annual sales pace of 276,600. That was the slowest pace on records dating back to 1963.").

without having to deal with legacy obligations artificially kept unrealized on both the public and the private books. I think that this tough-minded view is exactly the right sentiment to hold on that issue. The miserable performance of the government's Home Affordable Modification Program<sup>46</sup> (HAMP) is typical of the current situation. With the equivalent of glossy government online brochures<sup>47</sup> coupled with slow implementation, high default rates persisted even after renegotiation took place.<sup>48</sup> Force feeding will not work. The mistakes of HAMP should serve as a warning bell for how we think about other initiatives, including those that pertain to health care.

Given these lessons, the basic diagnosis of the path of the ObamaCare legislation is already in, and it falsifies the naïve Baucus prediction that the distributive consequences of complex legislation are benign. Let me explain very briefly why this is supposed to be the case. According to White House estimates, some 31 million people who are currently outside the system will now be supplied with first class health care.<sup>49</sup> I regard this claim as a snare and a delusion. There is not enough money in the public treasury to give that number of people the lavish set of benefits mandated under ObamaCare. You cannot supply Cadillac health care<sup>50</sup> to that number of people, many of whom are in

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46. U.S. DEPT OF THE TREASURY, MAKING HOME AFFORDABLE: SUMMARY OF GUIDELINES (2009), available at [http://www.treas.gov/press/releases/reports/guidelines\\_summary.pdf](http://www.treas.gov/press/releases/reports/guidelines_summary.pdf).

47. See MAKING HOME AFFORDABLE, <http://www.makinghomeaffordable.gov> (last visited Nov. 3, 2010).

48. Darrell Issa & Jim Jordan, Opinion, *Cleaning Up the Mortgage Mess*, WALL ST. J. (Aug. 25, 2010), <http://online.wsj.com/article/SB10001424052748704075604575356663725805580.html> ("HAMP has failed to meet the administration's own projections. According to government figures released on Monday, only 434,716 homeowners have received permanent mortgage modifications as of July. Meanwhile, the Treasury Department has cancelled the temporary modifications of 616,839 borrowers, with 96,025 modifications cancelled last month alone.").

49. Remarks on Health Care Reform, 2010 DAILY COMP. PRES. DOC. 147 (Mar. 3, 2010), available at <http://www.gpoaccess.gov/pressdocs/2010/DCPD-201000147.pdf> ("Even those who acknowledge the problem of the uninsured say we just can't afford to help them right now, which is why the Republican proposal only covers 3 million uninsured Americans while we cover over 31 million.").

50. "Cadillac" health plans are high-cost health plans with low deductibles, drug coverage, vision and dental care, and low or no copayments. See Keith B. Richburg, *What Makes a Health Care Plan a 'Cadillac'?*, WASH. POST (Oct. 1, 2009), <http://www.washingtonpost.com/wp-dyn/content/article/2009/09/30/AR2009093004730.html>.



bad shape, while keeping the current levels of health care in place for everyone else who now finds coverage within the system.

One key problem is how to arrange for a system in which the government pays the bulk of the bill while the insured has options of which coverage to demand. This is not the usual price control problem of government intervention in private markets. Rather, this is a greater problem of trying to figure out how to limit private discretion when the individual who chooses coverage often pays less than 10% of the bill. There is no good way to estimate the dollars. Nor is there any private benchmark against which the coverage can be measured, given that the massive controls and taxes on the private sector will so influence prices that no one can treat this overheated and overregulated private market as the lodestar for the government-dominated subsidized market.

This overemphasis on health care benefits relative to other needs leads to real distortions when we know that it is quite unlikely that individuals in this targeted group would make this same level of heavy health care expenditures if they had received outright cash grants. Generally speaking, most people will intuitively gravitate towards an “equal-marginal” solution. They want their last dollar spent on health care to give them the same amount of benefit as it gives them on education, on food and shelter, on recreation, and on everything else. Exactly how they achieve that objective is hard to state in the abstract, but the want of concrete knowledge on this point furnishes no argument for additional government mandates. It is an argument for private choices because it is much easier for individuals to make their own equal-marginal judgments than it is for them to explain to everybody else how they made their judgments and why those outcomes are right for themselves, even if they might prove wrong for everybody else.

By pushing large new sums of wealth into health care in so haphazard a fashion, serving this new population will turn out to be more expensive than we might suppose. Yet the only place that that money can come from is out of the

hide of median voter,<sup>51</sup> either in terms of higher taxes or a value-added tax (VAT) which many European countries commonly use to fund their rather expensive welfare states.<sup>52</sup> Additionally, it is harder to make a VAT progressive even if the income tax is progressive. The VAT will become a broad-based tax, which will hit the middle class.<sup>53</sup> Here in the United States, the adverse consequences of ObamaCare are likely to cut more deeply, for the median voter is likely to lose his or her healthcare coverage from the implementation of this program. So much for the benevolent redistribution of Senator Baucus.

A quick look at calculations will, without question, confirm quantitatively what is known qualitatively. Just simply looking at the size and the scope of the obligation, it becomes evident that too much has been bit off too soon. First, just posit that the average benefit package will be provided at a cost, on average, of \$3,000 per person annually—an estimate that looks low. Multiply that by thirty million people, and you come up with a figure of around \$900 billion in annual expenditures if nothing is done to control the cost side, which is no easy task given the dominant role that the government as purchaser of health care services. As usual, ObamaCare makes no effort to reengineer services that could be rationally reorganized, such that the likely pushback will require doctors and other health care providers to receive fewer dollars while providing more extensive services.

The upshot will be that the same physicians—and it is not all physicians—who favor ObamaCare in the abstract<sup>54</sup> will

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51. See Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Hon. Jerry Lewis, Ranking Member, U.S. House of Representatives Appropriations Comm. (May 11, 2010) (on file with the Cong. Budget Office), available at [http://www.cbo.gov/ftpdocs/114xx/doc11490/LewisLtr\\_HR3590.pdf](http://www.cbo.gov/ftpdocs/114xx/doc11490/LewisLtr_HR3590.pdf).

52. Fred Lucas, *Obama Administration Sends Mixed Message on VAT as Fiscal Commission Prepares First Meeting*, CNS NEWS (Apr. 23, 2010), <http://www.cnsnews.com/news/article/64671>.

53. JANICE SHAW CROUSE, CONCERNED WOMEN FOR AM., OBAMANOMICS: SUMMARY OF THE ANALYSES AND COMMENTARY RELATED TO THE FINANCIAL IMPACT OF OBAMACARE ON WOMEN AND FAMILIES 31 (2010), <http://www.cwfa.org/images/content/Obamanomics.pdf> (noting that European value-added taxes average around 20% and in the United States, such a tax set at 10% could raise perhaps \$500 billion per year, or about \$4,300 per household).

54. See generally, Ryan M. Antiel, et al., *Physicians' Beliefs and U.S. Health Care Reform—A National Survey*, NEW ENG. J. MED. (Sept. 14, 2009), <http://www.nejm.org/doi/pdf/10.1056/NEJMp0907876?ssource=hcr>.

flee from the system when and if the new system of fee reimbursement is put into place.<sup>55</sup> Short of involuntary servitude, the government cannot alter the supply curve of physicians. Fewer dollars means fewer doctors. In particular, many primary care physicians near retirement age will elect to take that option. Take a physician at an age at which early retirement or job redeployment is a viable option—say, in his or her late fifties or early sixties. Early retirement becomes the only option if the government pushes through a decline in rates that will not allow physicians to cover their extensive costs in administering these new programs while simultaneously meeting preexisting obligations (including rent and support staff). The usual consequence of price controls is shortages; thanks to ObamaCare, we can expect shortages in the supply of physicians, and particularly in those who supply primary care.

The situation will get worse because the economics of private health care plans will be so costly that the payment of penalty tax amounting to 2.5% of their household income may look attractive to nearly four million people.<sup>56</sup> This disintegration of the private health care system may well be the ulterior motive of many ObamaCare supporters who think that a single-payer system can avoid the many pitfalls of the current market. But if so, the campaign for ObamaCare will have turned out to be a classic case of bait and switch.

A central theme of the Obama's 2008 campaign and the early months of his presidency was that "[i]f you have insurance that you like, then you will be able to keep that insurance."<sup>57</sup> In retrospect, this was not a real promise. The first thing you discovered when you looked at the statute is that the definition of a "grandfathered health plan" is wholly unclear. Right now we know that adding new employees or new dependents of old or new employees does not deny a

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55. See *infra* note 94.

56. Stephen Ohlemacher, *Nearly 4M People Could Pay Without Health Coverage*, YAHOO! FINANCE (Apr. 22, 2010), <http://finance.yahoo.com/news/Nearly-4M-people-could-pay-apf-2747238688.html>.

57. Remarks at a Town Hall Meeting and a Question-and-Answer Session on Health Care Reform, 2009 DAILY COMP. PRES. DOC. 604 (July 28, 2009), available at <http://www.gpoaccess.gov/presdocs/2009/DCPD-200900604.pdf>.

plan protected status. But it is not clear from reading the act exactly what happens if there are any other changes to the plan, such as changes in coverage, price, mergers, and the like. As one study noted, “[i]t is still not clear, however, whether any significant modifications of coverage under a plan design will alter its grandfathered status,”<sup>58</sup> a regrettable state of affairs that once again shows the enormous impact that the regulations will have on the scope of the action. It could easily turn out when the dust settles that any important change is tantamount to creating a new plan and losing their protected status.

Of course, every health plan is amended countless times in order to take into account difference in rates, coverage, benefits, formulas, and so forth. By one reading of the statute definition, each of us, quite without our own knowledge, has been enrolled in hundreds of different plans over the years, all of which, strangely, have had the same single plan number. But even for grandfathered plans that run this gauntlet, the established rules are not inviolate. There are phased introductions of substantive requirements that apply to these plans, dealing with key issues such as preexisting conditions, coverage for dependents up to age twenty-six, rescission, and coverage limits, each of which has its own complex web of interpretive rules.<sup>59</sup> It looks like a classical instance of undermining ordinary expectations with a set of highly restrictive and counterintuitive statutory definitions. But regardless of the rhetoric, within five years the original grandfathered plan will be as extinct as the dodo.

But before then, all these fine points really matter. The new plans do not get statutory protection from government oversight. The new plans all have to receive that benediction, which they can only get if they run through a regulatory gauntlet, which—in total disregard of marginalist principles—operates as though more health care is invariably better for the consumer than less. But without any grandfathered protection, everyone starts at square one

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58. BENICO, GRANDFATHERED HEALTH PLANS AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010), *available at* [http://www.benico.com/docs/Grandfathered\\_health\\_plans\(PPACA\).pdf](http://www.benico.com/docs/Grandfathered_health_plans(PPACA).pdf) (discussing ObamaCare § 1251 (Preservation of Right to Maintain Existing Coverage)).

59. *Id.* at 2.

in a regulatory environment that is not quite to their liking. In time, historical continuity was displaced by a view that additional levels of consumer protection were required, without any real showing of systematic dissatisfaction by the people who were actually enrolled in these various plans. Throw in mandates and other regulatory hurdles, and the administrative load becomes truly high. Yet higher taxes and higher unemployment levels can accentuate the downward slide in a double dip recession, which will add more people to an overextended public sector with an insatiable appetite for huge, but unfunded, state subsidies.

#### IV. THE MASSACHUSETTS EARLY WARNING SYSTEM

There are many people who think that such gloomy forecasts are inappropriate.<sup>60</sup> Unfortunately, we already have an early warning signal that no combination of taxes and regulations can cover the expanded obligation base. That warning comes in the form of the extended legal battle now taking place in Massachusetts over RomneyCare,<sup>61</sup> the so-called “Republican model”<sup>62</sup> for the national health care plan. In February 2010, Massachusetts Governor Deval Patrick persuaded his insurance commission to switch from a “notice” system to a “prior approval” system of rate regulation in reviewing the new set of rate packages put forward by the various health care plans.<sup>63</sup>

The difference between the notice and approval systems is huge in dealing with insurance. A notice system is essentially a full disclosure system. Pilgrim Health Care, a large state insurer, has to give notice to the state commission of how it plans to proceed with various groups of insureds. Thus, it is imperative that the insurer supplies the

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60. For a view typical of the ObamaCare boosters, see Jonathan Cohn, *On the House*, NEW REPUBLIC (Jan. 5, 2010), <http://www.tnr.com/article/health-care/the-house>.

61. An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 MASS. ACTS ch. 58, available at <http://www.malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58>

62. See Edmund F. Haislmaier, *Mitt's Fit: Romney's Health Plan Is No Sop to Socialism*, NAT'L REV. ONLINE (Jan. 27, 2006), <http://old.nationalreview.com/comment/haislmaier200601271110.asp>.

63. Kay Lazar, Michael Levenson & Robert Weisman, *Patrick Wants Health Cost Veto*, BOS. GLOBE (Feb. 11, 2010), [http://www.boston.com/news/local/massachusetts/articles/2010/02/11/patrick\\_wants\\_health\\_cost\\_veto/](http://www.boston.com/news/local/massachusetts/articles/2010/02/11/patrick_wants_health_cost_veto/).

plans that it announces, as a check against insurer fraud by way of a bait-and-switch operation. However, the firm that supplies notice has complete freedom in setting its rates without any administrative hassle or blowback. The insurance commission relies on competition to restrain rates. It makes no effort to try to figure out which rates give the firm a suitable rate of return.

The moment a state switches to an approval system, it has essentially abandoned that disclosure model in favor of a new procedure that lets government agents determine whether or not industry firms have garnered “excessive profits.” Now some may say that this is something that governments always do when dealing with regulated industries. That proposition is both right and wrong. Such government approval is something governments do when they regulate industries with some kind of a monopoly power—typically the network industries that supply power or telecommunications utilities.<sup>64</sup> But it is not the kind of task that governments usually undertake with regard to competitive industries, where there are no monopoly profits to bleed out of the system. What government regulation can do in competitive industries is create mischief by reducing the prices charged by participant companies so that they cannot earn a competitive rate of return, even as they are forced to bear the new compliance costs of a regulatory regime that treats their every action under a presumption of distrust.

In principle, an approval system should give rise to serious constitutional challenges, even under the very weak laws of property protection that exist in other areas.<sup>65</sup> With rate regulation, the law requires concern over whether the rates allowed permit the company to earn a risk-adjusted rate of return.<sup>66</sup> Both Massachusetts and Maine, however, have explicitly disavowed that standard. Their definition of

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64. See generally, LAWRENCE J. WHITE, U.S. PUBLIC POLICY TOWARD NETWORK INDUSTRIES 22 (1999).

65. For a discussion of the constitutional implications of regulation, see Richard A. Epstein, *Exit Rights and Insurance Regulation: From Federalism to Takings*, 7 GEO. MASON L. REV. 293 (1999). For a more general statement of the problem, see Richard A. Epstein, *Exit Rights Under Federalism*, 55 LAW & CONTEMP. PROBS. 147 (1992).

66. See, e.g., *Duquesne Light Co. v. Barasch*, 488 U.S. 299, 315–16 (1989).

“excessive” is no longer whether one receives a monopoly rate of return, which everybody admits that you are not. Rather, the newer definition of “excessive” now condemns making the kinds of profits that only seem to be inappropriate to a large firm at a time when there are many people without any healthcare coverage at all. That share-the-wealth—and share-the-misery—approach has made a difference. The Massachusetts Insurance Commission in February 2010 managed to reject 235 out of 274 proposed rate increases, promising to allow only smaller increases in exchange.<sup>67</sup> In the interim, the insurance companies announced that they would not sell insurance coverage to some 800,000 individuals in that market niche until the legal position had been clarified.<sup>68</sup> Massachusetts did not take this threat to leave lying down and responded that it would fine any company with the temerity to withdraw from the local market. In response, the insurance carriers filed a lawsuit seeking to knock out the statute, but the Massachusetts Superior Court quickly announced that it would only hear the case after the matter had gone through several additional months of administrative hearings.<sup>69</sup> In the interim, the court was not prepared to allow the companies any level of increased revenues, deeming that their cash position was strong enough to avoid bankruptcy and that they could recoup the additional fees from their many individual policyholders to the extent that these might be ultimately granted.<sup>70</sup> Several days later, the same court held that the state was entitled to enforce its rate orders in part because its orders were endowed with a presumption of legitimacy, which meant that the state did not have to prove irreparable harm to force the individual insurance

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67. Paul Howard, *Bay State Health-Care Blues*, NAT'L REV. ONLINE (Aug. 5, 2010), <http://www.nationalreview.com/articles/243613/bay-state-health-care-blues-paul-howard>.

68. Thomas Cheplick, *Massachusetts Health Insurance Rate Cap Creates Legal, Financial Problems*, HEARTLAND INST. (Aug. 7, 2010), [http://www.heartland.org/healthpolicy-news.org/article/28147/Massachusetts\\_Health\\_Insurance\\_Rate\\_Cap\\_Creates\\_Legal\\_Financial\\_Problems.html](http://www.heartland.org/healthpolicy-news.org/article/28147/Massachusetts_Health_Insurance_Rate_Cap_Creates_Legal_Financial_Problems.html).

69. *Mass. Ass'n of Health Plans v. Murphy*, No. 10-1377-BLS2, 2010 WL 2102726 (Mass. Super. Apr. 12, 2010).

70. *Id.* at \*10–11.

companies to remain in the marketplace.<sup>71</sup> The older tradition whereby the constitutionality of rates was determined before they were put into effect has not been followed.

The Massachusetts saga has yet to wind itself down. But the situation is ominous. The procedural delays could easily slow down the review of the applications for rate increases next year. Ultimately, there are two scenarios: either the companies win and they pull out of the state, at which point Massachusetts has a real problem of how to supply coverage when faced with heavy deficits, or the companies lose, at which point they go bankrupt in the short run and the state has to face exactly the same problem, only on a larger scale. In Massachusetts, the rock and the hard place are the only two possible outcomes. The ostensible purpose of *ObamaCare* is that when government imposes rates regulation on private firms, they will unearth magical efficiencies that no one thought possible. Necessity is thus the mother of invention, and firms innovate in ways that they did not think possible before the government intervened. But this bit of wishful thinking ignores the reality of the competitive forces which drive firms to find low-cost ways to deliver health care. And it understates the likelihood, which is already in place, that smaller firms will rush to find larger partners in order to rid themselves of the high fixed costs of regulatory compliance.<sup>72</sup> Concentrated industries may be less than ideal, but they are preferable to bankrupt firms.

## V. THE DARTMOUTH ATLAS

The ostensible reason for why health care is “different” is that it should be possible to squeeze out the waste in the system through prudent price regulation. One impetus for the Massachusetts plan was the comprehensive reviews on the cost of delivering health care in the United States

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71. *Mass. Ass’n of Health Plans v. Murphy*, No. 10-1377-BLS2, 2010 WL 2102723 (Mass. Super. Apr. 23, 2010).

72. See Robert Pear, *Consumer Risks Feared as Health Law Spurs Mergers*, N.Y. TIMES (Nov. 20, 2010), <http://www.nytimes.com/2010/11/21/health/policy/21health.html>.



through the Dartmouth Atlas,<sup>73</sup> which announces its mission in no uncertain terms:

For more than 20 years, the Dartmouth Atlas Project has documented glaring variations in how medical resources are distributed and used in the United States. The project uses Medicare data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. This research has helped policymakers, the media, health care analysts and others improve their understanding of our health care system and forms the foundation for many of the ongoing efforts to improve health and health systems across America.<sup>74</sup>

The immediate question raised by these studies is why these gaps do not disappear under the force of market pressures. There are two explanations. The first starts with restriction of the Dartmouth Atlas to “Medicare Data,” which is *not* a randomly selected set of data.<sup>75</sup> It is data that comes exclusively from one, albeit massive, government program. To the extent that these price differentials are unjustified, it represents condemnation on how government provides its services. If twenty years of work has not eliminated these gaps, why think that clever maneuvers in the next iteration of health care reform will change the results?

At this point, two questions surge to the fore. The first is whether these price differentials are found on the private side of the marketplace, for which the answer seems to be no. Tomas Philipson and his colleagues have done careful studies for paired patients in Medicare and in private plans which show that the differentials are far smaller in the private sector than under Medicare,<sup>76</sup> largely competed away on the private side where the gaps are in the order of three

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73. See DARTMOUTH ATLAS OF HEALTH CARE, <http://www.dartmouthatlas.org/> (last visited Nov. 25, 2010).

74. *Id.*

75. See *Frequently Asked Questions*, DARTMOUTH ATLAS OF HEALTH CARE, <http://www.dartmouthatlas.org/gettingstarted/faq/> (noting that the Atlas “focus[es] on Medicare data”).

76. Tomas J. Philipson et al., *Geographic Variation in Health Care: The Role of Private Markets*, 2010 BROOKINGS PAPERS ON ECON. ACTIVITY: SPRING 325.

to four times smaller.<sup>77</sup> On this model, the sensible response is to deviate away from Medicare in order to find a relatively fast way to control for differences.

A second difficulty with the Dartmouth studies is that they do not control for success. The studies on price differentials often show the costs incurred in the year before death, which can vary substantially by institutions. But in and of itself, it shows nothing until evidence is presented about the people in the different treatment centers who *live*. A cancer program that saves 60% of its patients may well cost more than one that saves only 20% of its patients. But the cost differential that seems justified by these outcomes is lost if you only look at the dead patients in both groups.

Put both of these points together, and it becomes clear that the overall estimations of health care effectiveness are very difficult to make. Yet it is an implicit assumption behind ObamaCare, like it was behind the Massachusetts system, that regulation of the private sector could eliminate its persistent and large inefficiencies in the private sector, and so too for the endemic weaknesses in the government sector. But the former is in all likelihood more efficient than was presupposed, and the latter is more difficult to correct. The false optimism of comprehensive health care reform follows from the combined impact of these two plans. But owing to the complexity of the underlying institutional arrangements, one pointed prediction is that imposing price controls on top of the current system will not improve matters in either the short or long run. It is yet another instance where the Baucus hope of smooth redistribution is so misguided.<sup>78</sup> The Baucus approach creates a greater level of confusion and chaos than is now in place, as everybody tries to scramble for some private advantage. Some firms will get windfalls; some will disappear in mergers and other takeovers; and still others will perish. The upshot is a demand for nationalization, now that the so-called private sector will have failed yet again.

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77. *Id.* at 350–51.

78. See *Dem Senator: Health Legislation Will Address the “Mal-Distribution of Income in America,”* *supra* note 37.

## VI. SOME MECHANICS OF OBAMACARE

As with so much complex legislation, lofty objectives are often undermined by sloppy mechanics, and nowhere is that more true than with ObamaCare. I will discuss two major problem areas apart from what I have previously discussed above: first, the private insurance exchanges, and second, state involvement with Medicare and Medicaid.

A. *Private Insurance Exchanges*

The first major challenge for ObamaCare is to structure its so-called “insurance exchanges.”<sup>79</sup> Like all exchanges, the health care exchange is not an open access regime. The only insurers entitled to join that exchange have to meet certain key requirements: for example, the kinds of coverage they have to supply, the persons to whom they must supply it, and the number and types of individuals they have to enroll. The fixes here standardize some portion of the insurance deal in ways that undermine the ability of innovative firms to gain greater market share by altering the type of coverage that they choose to supply.

Here is one example of the problem: in ordinary private markets, individual firms often specialize in particular niches where they have expertise. Some insurance companies will target the main consumer markets; others may choose to specialize in older populations or those subject to the risk of certain kinds of diseases, such as cancer or heart attacks. High-risk customers can afford huge opportunities for insurers to profit by managing risk, so long as the firm is able to charge premiums that cover both the risks that remain and the administrative costs of reducing those risks to an acceptable level. Because specialization in subpopulations is a way in which most insurance markets work, there is no reason to force all insurance companies to offer coverage in geographical regions they do not want to go or in patient populations they do not wish to cover. The secret to success in every market is the ability of a firm to

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79. For my earlier account on this score, somewhat outdated by the passage of events, see Richard A. Epstein, *Impermissible Ratemaking in Health-Insurance Reform: Why the Reid Bill Is Unconstitutional*, MED. PROGRESS TODAY (Dec. 18, 2009), [http://www.medicalprogresses.com/enewsletters/mpt\\_ind.php?pid=1834&nid=250](http://www.medicalprogresses.com/enewsletters/mpt_ind.php?pid=1834&nid=250).

move simultaneously on multiple margins so as to get the best mix for it and its customers. The need is to keep prices high enough to cover costs but low enough to keep and attract customers. Any and all efforts to maximize profits must be made in light of the threat of entry. Nothing concentrates the mind so well.

Now, nobody can say that this art of designing an insurance policy, or indeed a complex array of insurance policies, always succeeds. Yet by the same token, no one should ever insist on matters of system design that the best be the enemy of the good. What can be said with some confidence about these health care programs is that they do a pretty good job of mixing, matching, and monitoring. In running a health care network, it is extremely difficult to make sure that physicians perform as desired, given the manifest agency-costs problems in overseeing highly paid professionals. Every physician is going to be under constant pressure by patients who want ever more care for fixed payments that they have already made. Physicians often show personal loyalties to their patients. But every time an insurer or other health care provider lets expenses run out of control, the added costs are borne by other patients. At some point—I do not know where that point comes—the health care provider has to act like the Grinch. Profligacy will jeopardize the long-term sustainability of the health care program.

One certain road to perdition in this environment is to make a decision to honor all patient health care requests that provide some value for their patients. It is never the right question to ask whether in each instance a health care plan provides benefits greater than zero. The answer to that question is virtually always yes. The harder question for the health care provider is whether the benefit sought is greater than the cost of supplying it, for which there are no clearly quantifiable answers on either the benefit or the cost side of the equation. Thus, any successful firm has to develop very accurate internal measures and maintain strong internal controls to succeed, all of which relate to its patient base and physician pool. The ability to collect and interpret aggregate data is critical. This process necessarily requires the successful firm to take some, but not all, control over

patients out of the hands of physicians. One reason why many doctors do not like health maintenance organizations (HMOs) and insurance companies is that they use overall measurements and tested protocols to displace the judgment of individual physicians who are trained to have unwavering confidence in their own judgment.

These tasks are made vastly more complex if any health care plan is required to accept all comers,<sup>80</sup> without rights of refusal based on preexisting medical condition or other background risk conditions.<sup>81</sup> Companies are similarly subject to obligations for the guaranteed renewal of coverage<sup>82</sup> and are denied any rights of rescission.<sup>83</sup> Underwriting is thus removed by participation on the exchange, which is a de facto necessity to attract the government contribution to individual patients. At this point, a good reputation can work in reverse by leading to an oversubscription of patients whom the plan does not have the capacity to serve. Somebody has to be refused. Unfortunately, under ObamaCare, an external randomized program determines who gets accepted and who gets rejected, without regard to the way in which the composition of the patient pool may influence the costs of providing needed services. ObamaCare does not have any obvious dollar-for-dollar revenue offset even for those insurers taking on an abundance of high-cost and high-risk patients, including those with known and expensive preexisting conditions. Any firm's ability to market to discrete populations through age, sex, disease, condition, or location segmentation is heavily compromised.

And it gets even worse. While the firm has an obligation to take patients with known disabilities, the patients have no obligation to stay with the firm. The adverse selection problem thus grows by leaps and bounds. The experience under the Massachusetts law bears this out.<sup>84</sup> People sign

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80. See ObamaCare § 2702 (Guaranteed Availability of Coverage).

81. See *id.* § 2704(a) ("A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.").

82. See *id.* § 2793 (Health Ins. Consumer Info).

83. See *id.* § 2712 (Prohibitions on Rescissions).

84. See Kay Lazar, *Short-term Customers Boosting Health Costs*, BOS. GLOBE (Apr. 4, 2010), <http://www.boston.com/news/local/massachusetts/articles/2010/>

up just before they need major treatment, and then withdraw from the plan when their treatment is completed. The premiums cannot adjust to the risk because the implicit assumption in this market is that only insurers play questionable games in dealing with patients. But that assumption goes against the entire history of insurance law, in which the greater knowledge that insureds have of their condition imbues them with duties to disclose relevant conditions to the insurer. This authorizes insurers to write policies that protect them against this risk of adverse selection, which has individuals sign up when they know that their expected benefits will exceed their premiums.<sup>85</sup> The Massachusetts plan thus has the risks running in the wrong direction, which is what happens when a deep ideological priority blocks a more serious consideration of where the real risks lie.

Unfortunately, there is no effective firm response once consumer opportunism is allowed to run riot. The only way to make up the loss on problem cases is through premium hikes on well-behaved plan participants, but at this point those healthy individuals have a strong incentive to leave the pool because their risks are not sufficiently large to justify the added costs. Thus, the whole market on the private side unravels unless the state imposes heavily coercive measures on well-behaved customers. But there is no reason why the preexisting conditions have to present an insuperable obstacle to rational insurance markets. In the mid-1990s, John Cochrane of the University of Chicago Booth School of Business and I independently developed a contractual solution that relies on long-term contracts to

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04/04/short\_term\_customers\_boosting\_health\_costs/ ("Thousands of consumers are gaming Massachusetts' 2006 health insurance law by buying insurance when they need to cover pricey medical care, such as fertility treatments and knee surgery, and then swiftly dropping coverage, a practice that insurance executives say is driving up costs for other people and small businesses.").

85. See, e.g., *Lindenau v. Desborough*, 108 Eng. Rep. 1160, 1163 (1828) (Bayley, J.). In *Lindenau*, the court stated,

I think that in all cases of insurance, whether on ships, houses, or lives, the underwriter should be informed of every material circumstance within the knowledge of the assured; and that the proper question is, whether any particular circumstance was in fact material? [sic] and not whether the party believed it to be so.

*Id.*

handle the problem of preexisting conditions.<sup>86</sup> The basic idea is as follows: In the good state of the world when you are twenty-five, like most graduate students, you go out and buy two kinds of insurance. The first kind is insurance to cover you for the present year, and the second is a different kind of insurance that gives you “bad news” coverage in the event that some bad condition should show up in your life. If an insurance carrier could keep everybody in these programs, the amount of money that an insurance carrier earns on the “bad news” portion of the premium situation should be able to cover the higher rates needed for those people with newly emergent conditions.

Note that this program gives all young people an incentive to buy insurance early. That is the exact opposite of the current situation in Massachusetts, where it pays for people to wait until they get bad news before buying insurance. However, this two-part plan only works if the companies that supply it can be sure that they can keep all the “bad news” money if their insureds decide to cancel their policy. At this point, job portability can be improved because the bad news part of the coverage can be transferred across insurers if workers change jobs. Yet the whole program will fall to pieces if healthy insureds are allowed to withdraw from the program at will, recovering their bad news premiums in full once they chose to leave the system. A viable long-term system depends on holding both insureds and their insurers to their long-term contracts. Yet once health care becomes a “right,” no one has a real incentive to buy protection when healthy for the time that they become sick. Better to wait when the now-preexisting condition does not allow the insurer the right to raise premiums or exclude you from the plan. There is, sadly, a bipartisan consensus in favor of this fashionable-but-flawed view of insurance without any correlation between the risk assumed and the premiums collected.<sup>87</sup>

There is a lesson to be learned about the stability of insurance plans. No plan will prove to be stable if people can

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86. See RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE 138–40 (1997); John H. Cochrane, *Time-Consistent Health Insurance*, 103 J. POL. ECON. 445 (1995).

87. See, e.g., *Access to Affordable Health Care*, *supra* note 34.

enter and exit at will in order to pick up subsidies that someone else has to pay. Voluntary markets may well price some people out of the market, but they surely prevent the fatal disintegration which shuts down the market. So long as no one receives a conscious cross-subsidy, people will stay in a plan that costs them less than it is worth. If their premiums are computed correctly, they no longer worry about the composition of the pool, no matter who else is in the plan. They will always look for better offers, which will come only from a company that can provide the same coverage for less, precisely as things should be in a competitive environment. The great genius of this system is that it does not matter to anyone who else has insurance from this company. But if each person has to insure the risks of others, then everyone wants to be in a pool where they receive subsidies from others, which is a simple impossibility. The moral is this: think of insurance for yourself as a right, and be prepared to have it become a duty.

These exchanges, therefore, are faced with difficulties at every turn, given that there is no pricing system that can handle the implicit subsidies given to so many individuals at one time. These exchanges could easily break down. Just because an exchange is open for business does not mean that somebody will decide to participate in it. These logistics are not easy to resolve. It will not be easy to push employers or insurers much harder. Nor can one push harder on health care providers. So it is back to the usual outcome under price controls. It is necessary to constrain prices by letting let people form queues, which dissipate some of the demand. That will happen in the United States, as it has long occurred in Canada.<sup>88</sup> How long the queue becomes depends on the size of the subsidies to those in need of health care. There are no easy fixes.

### *B. State Involvement with Medicare and Medicaid*

The difficulties on the private side are matched by those on the public side, through Medicare and Medicaid, whose

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<sup>88</sup> See, e.g., Clifford Krauss, *Long Lines Mar Canada's Low-Cost Health Care*, N.Y. TIMES, Feb. 13, 2003, at A3.



pricing structures do nothing to constrain the demand for medical services. Nobody who has looked at Medicare finances over the last ten years questions these particulars. But on the question of whether the system will become insolvent, the only question is when: 2016, 2018, or 2022? The 2010 Annual Report for the Trustees of Social Security and Medicare states officially that the passage of ObamaCare has pushed back by twelve years the date at which Medicare is anticipated to go insolvent, from 2017 to 2029.<sup>89</sup> It sounds, therefore, that it is possible to get blood from a stone. But the same report that makes this rosy report contains an unusual disclaimer by Richard S. Foster, its chief actuary, which reveals the exact opposite message, worth quoting in part:

[T]he financial projections shown in this report for Medicare do not represent a reasonable expectation for actual program operations in either the short range (as a result of the unsustainable reductions in physician payment rates) or the long range (because of the strong likelihood that the statutory reductions in price updates for most categories of Medicare provider services will not be viable).<sup>90</sup>

Mr. Foster has put his finger on the essential difficulty. The numbers that the Medicare report relied upon are make-believe. ObamaCare included a set of cuts in reimbursement fees that are not sustainable. Congress has imposed these restrictions before but has always relented in order to keep doctors inside the system. The same scheme will play out on a grand scale under ObamaCare. Foster does give his estimate of when the system will go into debt, but without some genuine change, that date will come sooner than 2017, and certainly not later.

Medicaid is in the same dire straits. Right now it is a dominant component of most state budgets. States, such as Illinois, are consistently in arrears on their payments for nine months up to one year, simply because they cannot

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89. SOC. SEC. AND MEDICARE BDS OF TRS, A SUMMARY OF THE 2010 ANNUAL REPORTS (2010).

90. RICHARD S. FOSTER, STATEMENT OF ACTUARIAL OPINION, 2010 ANNUAL REPORT OF THE BDS. OF TRS. OF THE FED. HOSP. INS. & FED. SUPPLEMENTAL MED. INS. TRUST FUNDS 282 (2010).

meet the revenue requirements.<sup>91</sup> No private institution can afford to wait that long for reimbursement without getting a costly interim line of credit financing, because workers and customers cannot wait that long for their repayment.

Now, what is going to happen? On Medicare, it may be possible to means-test some of the benefits, which will make a small dent in the program but not much. Right now, there are different rates for individuals in different income brackets, but those charged to the richest taxpayers are still well below cost. I do not expect that to change radically in the near future. It seems almost foolish to ask if political wisdom exists in Washington to make the hard choices. The answer, of course, is that there is none. Partisanship here is not necessary because there are few Republicans willing to call for a reexamination of the benefit structures under Medicare from the ground up. Rather, during the debate over ObamaCare, most Republicans treated the need to protect this massive subsidy for their preferred clientele as an objection to introducing a second one. What is needed is more Republicans who are prepared to look hard at the embedded cross-subsidies driving the Medicare program. What is not needed is more Democrats living under the delusion that we can afford to expand Medicare subsidies to just about everyone. In this case the intellectual rot starts at the top: knowing presidential gazes, lofty claims, and rhetorical self-confidence do not a coherent health care program make.<sup>92</sup> We cannot reduce deficits by first spending

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91. See Emma Jackson, *Tough Choices Ahead as State Fiscal Crisis Threatens Illinois' Medicaid Program*, MEDILL REPORTS (Feb. 17, 2010), <http://news.medill.northwestern.edu/chicago/news.aspx?id=157156>. Jackson reports,

Medicaid liabilities roughly total \$663 million, according to the Illinois Dept. of Healthcare and Family Services, and monthly payments to safety net hospitals aren't covered under the prompt pay requirements, leaving those providers out in the cold . . . . With tax revenues at a record low, Illinois has been using short-term borrowing to fix the Medicaid funding crisis.

*Id.*

92. See, e.g., Remarks to the American Medical Association National Conference in Chicago, Illinois, 2009 DAILY COMP. PRES. DOC. 466 (June 15, 2009), *available at* <http://www.gpoaccess.gov/presdocs/2009/DCPD-200900466.pdf>. There President Obama stated,

[W]e will keep this promise: If you like your doctor, you will be able to keep your doctor. Period. If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No

trillions of dollars in the hope that the money will materialize from economic growth that is already being stifled by the prospect of higher taxes in 2011. Nor is it possible to balance a budget by collecting taxes over ten years and spending the revenues within seven years.<sup>93</sup>

On the Medicaid side, matters are even more complicated because ObamaCare hopes to ramp up the payments for Medicaid recipients. It will offer some federal subsidies in the short run, but in the long run, it will be up to the states to pick up an ever larger share of the bill.<sup>94</sup> A convenient summary of these complex provisions is found in a complaint that Florida and other states have brought against the United States government for its encroachment on state sovereignty through the operation of this program. It is worth quoting in full, if only to illustrate the massive but unsustainable nature of this program:

40. The Act requires states to expand massively their Medicaid programs and to create exchanges through which individuals can purchase healthcare insurance coverage. The federal government is to provide partial funding for the exchanges, but will cease doing so after 2015. Should a state not wish to participate in the exchanges, it can opt out only if it provides coverage for uninsured individuals with incomes between 133 percent and 200 percent of the federal poverty level, a higher income level than that which would be applied for participating states under the Act. The only other way for a state to avoid the Act's requirements is to drop out of the Medicaid program, leaving millions of persons uninsured.

41. Those states left with no practical alternative but to participate in the Act will have to expand their Medicaid coverage to include all individuals under age 65 with incomes up to 133 percent of the federal poverty level. The states' coverage burdens will increase significantly after 2016, both in actual dollars and in proportion to the contributions of the federal government.

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matter what. My view is that health care reform should be guided by a simple principle: fix what's broken and build on what works.

*Id.*

93. THE HENRY J. KAISER FAMILY FOUND., MEDICARE FACT SHEET: MEDICARE SPENDING AND FINANCING (2010), <http://www.kff.org/medicare/upload/7305-05.pdf>.

94. See generally ObamaCare § 2201 (Enrollment Simplification and Coordination with State Health Insurance Exchanges).

42. The federal government will not provide necessary funding or resources to the states to administer the Act. Nevertheless, states will be required to provide oversight of the newly-created insurance markets, including, inter alia, instituting regulations, consumer protections, rate reviews, solvency and reserve fund requirements, and premium taxes. States also must enroll all of the newly-eligible Medicaid beneficiaries (many of whom will be subject to a penalty if they fail to enroll), coordinate enrollment with the new exchanges, and implement other specified changes. The Act further requires states to establish an office of health insurance consumer assistance or an ombudsman program to advocate for people in the new programs.<sup>95</sup>

On this occasion, I do not wish to comment on the constitutional issues raised by this provision.<sup>96</sup> The states face a Hobson's choice. They are technically not required to participate in this program, but if they don't, they will be forced to take up insurance without federal assistance for many of their neediest residents. Correspondingly, their citizens will be forced to pay into the federal treasury to support Medicaid payments to citizens in other states. So companies have to stay in, but the denial of an effective exit right does not put the needed dollars in the state to cover these onerous obligations. The specter of large pensions for public employees is not some abstract danger down the road. It is a present reality for the many major states forced to slash other programs relating to social services and education at both the K-12 and university level.<sup>97</sup> There is only so long that anyone can pretend that fiscal woes at one level of government can be cured by payments from some other level of government. If federal, state, and local governments all face serious problems with bloated public budgets, none can lend a boost to any of the others. The only interesting question is not whether any of these ships can

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95. Complaint at 10–11, *Florida v. Dep't of Health & Human Servs.*, No. 3:10-cv-91 (N.D. Fla. Mar. 23, 2010).

96. See Richard A. Epstein, *ObamaCare's Phony Medicaid 'Deal': The New Health Law Unconstitutionally Coerces the States*, WALL ST. J., May 10, 2010, at A15.

97. See, e.g., *N.J. Gov. Chris Christie's Budget Is Expected to Slash School Funds by \$820M*, NJ.COM (Mar. 15, 2010), [http://www.nj.com/news/index.ssf/2010/03/nj\\_school\\_officials\\_budget\\_cut.html](http://www.nj.com/news/index.ssf/2010/03/nj_school_officials_budget_cut.html).

right themselves under their current burdens. It is the sadder question: which of these ships will sink first, and will it bring down others in the undertow?

## VII. CONCLUSIONS: NEGATIVE SYNERGIES

We can now see the combined effect of ObamaCare on the public and private sides. The private insurance market is likely to implode under the combined weight of mandates and price constraints, which will hit hardest at the small and individual market. These market segments are likely going to prove unsustainable without subsidies, and probably unsustainable even with subsidies. But pushing these people into the public sector will not work, given the antiquated structure and shaky finances of both Medicare and Medicaid, neither of which is designed for universal coverage. But other sources of revenue are not available unless large segments of the economy are reformed, starting with bloated public pensions. Reform, therefore, will be a horrific struggle as it turns out that the only sacred contractual obligations in the eyes of some courts are those which states enter into with their unions. At bottom, these are only disguised multiperiod transfer payments from ordinary taxpayers to union retirees overpaid by a factor of two or three. To use the sanctity of contract argument to protect bloated payments resulting from self-dealing is the wrong way to go.

We can thus see the real dilemma, which explains why *Bleak Prospects* is an appropriate title for this Article. The health care problem cannot be cured on the backs of other institutions. Yet at present, there is no real willingness on the part of either political party to rethink this problem from the ground up. There is no easy way to handle this question if we try to regulate the terms and conditions of medical service in great detail. The more promising alternative is to find ways to provide relatively modest cash transfers to people on a need-basis to supplement the purchase of private health care insurance. Such an approach is exemplified by the program that Governor Mitch Daniels has implemented

in Indiana,<sup>98</sup> targeting individuals in need of assistance while ineligible for Medicaid.

Without a detailed analysis of the Indiana program, it should be sufficient to point out the philosophical orientation that animates its differences from the federal approach. ObamaCare starts from the assumption that private markets cannot work without heavy government oversight, which it imposes with ruinous consequences. In contrast, the Daniels program starts with the assumption that markets work well and then seeks to make modest wealth transfers to level access to health care, without trying to rework the system from the ground up. It adheres far more closely to the maxim of “redistribution last.”

Of course, the Indiana program is not pure laissez-faire, which might in fact be the better alternative if building a system up from the ground floor. But for these purposes, it is sufficient to point out that in a head-to-head comparison, in the early going, Indiana beats Massachusetts in a landslide. The only real question is whether intelligent reform at the state level can survive foolish regulation at the federal level. No one knows the answer to that question. But it is being becoming increasingly clear that the passage of ObamaCare has not ended the debate over health care reform in the United States. Perhaps the silver lining is that ObamaCare is so bad that it may not survive the rout of the Democrats in the November 2010 midterm elections. After all, as Rahm Emanuel once said, a crisis is too important to waste.<sup>99</sup>

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98. See Paul Howard, *Will ObamaCare Kill Indiana's Promising Experiment in Health-Care Reform?*, IDEAS IN ACTION (Aug. 4, 2010), [http://www.ideasinactiontv.com/tcs\\_daily/2010/08/will-obamacare-kill-indianas-promising-experiment-in-health-care-reform.html](http://www.ideasinactiontv.com/tcs_daily/2010/08/will-obamacare-kill-indianas-promising-experiment-in-health-care-reform.html).

99. See Gerald F. Seib, *In Crisis, Opportunity for Obama*, WALL ST. J., Nov. 21, 2008, at A2.

